Indiana PERF
Public Employees' Retirement Fund

RE-EMPLOYED RETIREE MEMBERSHIP RECORD & EMPLOYER CERTIFICATION OF ELIGIBILITY

State Form 50868 (R3 / 10-08)

Reset Form

PUBLIC EMPLOYEES' RETIREMENT FUND
143 West Market Street
Indianapolis, Indiana 46204-2899
Fax: (317) 234-5922

* This agency is requesting disclosure of Social Security Numbers in accordance with Internal Revenue Code; disclosure is mandatory and this form will not be processed without it.

INSTRUCTIONS:
1. *Please type or print. Use black ink.*
2. *Complete all information. Incomplete forms will be returned.*
3. *Return the completed form to PERF by mail or fax.*

ENROLLMENT INFORMATION ***(to be completed by the employer)***			
Social Security Number *		Date of birth (*month, day, year*)	
Name (*first, middle initial, last*)		Current marital status ☐ Single ☐ Married	Gender ☐ Male ☐ Female
Address (*number and street, city, state, and ZIP code*)			
Home telephone number ( )	Other telephone number ( )	E-mail address	
Date employed (*month, day, year*)	Position or title		

EMPLOYER CERTIFICATION

I certify that the individual named in this record is employed in an approved PERF-covered position. I understand that submission of this membership record creates a pension liability on the part of this employer and that employer contributions must begin with the date of hire. I have verified that the Social Security Number on this form is the same as the number used on our payroll and reported to the Internal Revenue Service for tax purposes.

I certify that I am the individual formally authorized to accept said liability for and on behalf of the governing body of this employer and that the date of employment listed above is correct.

Name of employer	Account number of employer
Signature of Authorized Agent	Date (*month, day, year*)
Printed name of Authorized Agent	

PREVIOUS MEMBERSHIP INFORMATION ***(to be completed by employee)***		
Have you previously been employed in a position covered by the Indiana Public Employees' Retirement Fund?	☐ Yes	☐ No
If yes, are you receiving benefits from the Indiana Public Employees' Retirement Fund?	☐ Yes	☐ No
Have you previously been employed in a position covered by the Indiana State Teachers' Retirement Fund?	☐ Yes	☐ No
If yes, are you receiving benefits from the Indiana State Teachers' Retirement Fund?	☐ Yes	☐ No
Have you previously been employed in a position covered by an Indiana retirement fund other than PERF or TRF?	☐ Yes	☐ No

MEMBER CERTIFICATION

I certify that the information I have provided in this record is, to the best of my knowledge, accurate and complete.

Signature of member	Date (*month, day, year*)
Printed name of member	

Name of member (*last, first, middle initial*)	Social Security Number *

STEP 3 - BENEFICIARY INFORMATION *(to be completed by employee)*

Primary Beneficiary or Beneficiaries

Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		
Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		
Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		

Contingent Beneficiary or Beneficiaries

Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		
Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		
Name of beneficiary (*last, first, middle initial*)		Social Security Number or tax identification number *
Date of birth (*month, day, year*)	Relationship to member	
Address (*number and street, city, state, and ZIP code*)		

In accordance with the provisions of Indiana Code § 5-10.2-3, I designate my beneficiary or beneficiaries for my Annuity Savings Account as shown above. If the primary beneficiary or beneficiaries herein designated survive me, they shall receive the funds, if any, that are payable by the fund to a designated beneficiary. If the primary beneficiary or beneficiaries do not survive me, then the contingent beneficiary or beneficiaries shall receive such funds. If none survive me, then the beneficiary shall be my estate. If no designation is made, any death benefit due will be payable to my estate. I reserve the right to change the primary or secondary beneficiaries at any time prior to retirement by filing a Change of Beneficiary form with the Board of Trustees of the Fund. Such a change must be received and accepted by the fund prior to my death for it to become effective.

I understand that this designation of beneficiary supersedes and replaces any prior designation of beneficiary that may have been made in the course of this or any prior employment after retirement in a PERF-covered position with any other employer.

Signature of member	Printed name	Date (*month, day, year*)